Office of Statewide Health Planning and Development

California Health Policy and Data Advisory Commission
1600 Ninth Street, Room 432
Sacramento, California 95814
(916) 654-1817
FAX (916) 654-1832
www.chpdac@oshpd.ca.gov

MINUTES
Health Data and Public Information Committee
May 21, 2004

The meeting was called to order by Vito Genna, Chairperson, at 10:30 a.m., in the HIRC Library, OSHPD, 818 K Street, Sacramento, California.

Present:	Absent:
Vito Genna, Chairperson	Jan Meisels Allen
Jay R. Benson	Stephen Clark
Vickie Ellis	Teri O'Rourke
Howard L. Harris, Ph.D.	
Denise Hunt	
Lark Galloway-Gilliam	
Darryl Nixon	
Catherine Nichols	

CHPDAC: Jacquelyn Paige, Executive Director; Raquel Lothridge, Executive Assistant; Janna Brady, Retired Annuitant

- OSHPD: David M. Carlisle, M.D., Director; Mike Kassis, Deputy Director, Healthcare Information Division; John Kriege, Healthcare Information Division; Kenny Kwong, Manager, Accounting and Reporting Systems Section; Jonathan Teague, Manager, Healthcare Information Resources Center; Scott Christman, GIS Coordinator; Deborah Wong, IT Project Manager; Robert Lew and Bruce Norton, Information Systems Section; Candace Diamond, Manager, Patient Discharge Data Section.

Chairman's Report: Vito Genna, Chairperson

The last meeting of this Committee was a joint meeting with the California Health Policy and Data Advisory Commission held in April. There was a review of the new staff-generated privacy policy. Because of increases in technology, data can potentially be identifiable. The Commission approved the new policy on disclosure that categorizes data into confidential and public data sets. The policy contains stronger language that mandates dissemination of information, but ensuring that a person's privacy is protected.

There was a discussion about a reduction in fees paid by facilities to support OSHPD's data program and the Commission and its committees. This reduction will reduce the reserve from $7 million to $4 million. At this time, resources needed are more manpower rather than financial.

The third discussion item concerned the charge master collection plans, mandated by AB 1627, which will be posted at the facility and reported to OSHPD to be posted on the website. Beginning on July 1, facilities will report their 25 most commonly charged services to OSHPD in a format specified by OSHPD. There was concern about creating a database that would not have much value, with limited resources, and that this information would not be useful. Also, what a facility bills a patient is not what is paid. Most of the payments are through Medicare, Medi-Cal, and third-party payers, so there is no correlation. Concern was raised as to whether Kaiser should be exempt. It was recognized, with caution, that there would be some benefit to collecting and analyzing this information, and was a step forward to force the public disclosure and public discourse debate. The Commission directed the Committee to go back and look at how this can be implemented without being such a burden on hospitals.

The regulations were approved for patient data reporting requirements to add emergency room and ambulatory surgery data collection. There was some concern about the reporting timeline and the coding information when a patient goes from a clinic to the hospital. It is automatically assumed there has been a complication. Admittance to the hospital from the emergency room is not considered a complication.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director

SB 1487 (Speier) proposes that hospitals report data on hospital-acquired infections to OSHPD. This bill is moving through the Legislature, and staff has had discussions with the author to discuss the bill, which is heavily supported by consumer organizations. Similar legislation has been passed in the states of Pennsylvania and Illinois. The purpose of the bill is to gain insight into the prevalence of nosocomial infections. It has been cited that 90,000 persons in the United States die annually from these infections.

AB 2876 (Frommer) proposes to add hospitals and local public health officers to those that may have access to a more detailed version of the discharge dataset. Currently, those users are limited to the University of California and other not-for-profit educational institutions.

The Technical Advisory Committee will meet on May 26. The first community-acquired pneumonia report is undergoing review by the Administration. The report is the first to use new variables added to the discharge data set. Condition present on admission is a complication that is identified upon admittance to the hospital. Do-not-resuscitate is important for adjusting the risk adjustment model and can affect the likelihood for mortality. The report contains information on models using the DNR variable and not using the variable. There will be reporting of outlier hospitals that have higher than expected mortality on both models.

Dr. Adams Dudley of University of California at San Francisco will be reporting on the California Intensive Unit Outcomes team. There is voluntary participation in this study by some hospitals.

OSHPD staff is moving forward with the implementation of California's mandatory coronary artery bypass graft surgery (CABG) program. There will be a report on hospital-specific findings for CABG outcomes. Surgeon-specific findings will be released for the first time in California. This is important because many cardiovascular surgeons practice at multiple hospitals in California.

OSHPD is in the midst of the budgetary process. The Governor's proposed budget contains no significant changes for the Office, although it proposed the addition of 50 new positions for hospital plan review. The budget recognizes the importance of seismic safety as well as the fact that the demand for plan review services has doubled in the last few years.

The budget also proposed continuation of General Fund support for the Song-Brown family practice training program, which has existed in California for about 30 years. The Senate budget subcommittee proposed that funding be diverted from the data fund for the next fiscal year and until an alternative funding source is found for the program. OSHPD fully supports the Governor's budget, which says General Fund support for Song Brown.

Reorganization within State Government is also underway. A Little Hoover Commission report issued recently would like to see a consolidation of programs within the Health and Human Services Agency to generate increased effectiveness, efficiency and cost savings in the Agency programs. The data and information functions are distributed broadly across every department within HHSA. The Agency recognizes that OSHPD collection activities are different than other department's activities.

Healthcare Information Resource Center: Jonathan Teague, Manager, Healthcare Information Resources Center

- Patient Quality Indicator Study of Diabetes and Diabetes Related Complications

  Mr. Teague described data exploration that OSHPD staff has been engaged in. The mission is equitable healthcare accessibility for California. Staff is developing some descriptive statistics to enable investigation of trends over time and variation by geographical regions, using ambulatory care sensitive conditions as a proxy for quality of care that is being received. Zip code is being used as the geographical descriptor. Patient discharge data are being used for years 1997 through 2003. The prevention indicators are from the Federal Government's Agency for Healthcare Research and Quality. There are 16 different ambulatory care sensitive conditions, typically measured as rates of admission.

  The four indicators selected for the initial study include diabetes, the short-term complications, long-term complications, and controlled. Diabetes was selected because of epidemic proportions nationwide. Per the Center for Disease Control, out of the 18.2 million people in the United States, 6.3 percent of the population is affected by diabetes currently. This includes 5.2 million persons that are undiagnosed. Adult prevalence has increased by 61 percent over the years from 1990 through 2000. Some parts of California seem to be more heavily hit than

others. There is evidence for disparate levels through different racial and ethnic groups. There has been an overall increase in the occurrence of diabetes and related disease. Some analysis suggests very high rates in children born in 2000. If the trend continues, about 32 percent of all boys and 38 percent of all girls will be suffering from diabetes.

Staff has been aggregating zip codes by counties. Certain counties seem to be more heavily hit than others, such as Central Valley, San Joaquin and Fresno counties. A limitation is the fact that zip code is the method used, and is not necessarily for measuring healthcare access. Mr. Teague went on to explain the specifics of the study.

A short-term objective is to look at graphs using the diabetes related quality indicators by doing a regional analysis, grouping similar to that used by the California Health Information survey in order to allow for some comparability. The enterprise geographical information system will also be used.

There is no policy at this time to share these internal studies and no mandate for doing these studies. The information being looked at will not be published and peer reviewed, but it is important information for policymakers and decision makers. The long-term goal is to go through all the 16 AHRQ prevention quality indicators to see how California statistics stack up this way.

A request was made for Mr. Teague to report at future HDPI meetings as a regular agenda item.

- Confidential Data Request Process

  The data privacy policy is a formal document that was signed by the Director recently. Confidentiality of information is paramount concern in disclosing information to outside requesters. There are two sources of legal input into the policy: Information Practices Act and the Health Data and Advisory Council Consolidation Act.

  There is a public data set that is de-identified by aggregation or masking. A main concern is to assure that there can be no external linkage of data. The non-public data is restricted, and will only receive the minimum amount of data necessary to do research. The review process includes the Committee for the Protection of Human Subjects (CPHS), the State's Internal Review Board (IRB) and OSHPD's internal review committee. The risk of identification is analyzed to prevent unnecessary disclosure. Disclosure of this data is limited to what is allowable under the law. CPHS approval is required for every confidential data request.

  AB 2876 is proposing to permit hospitals, local health officers and local public health departments access to a limited data set. The bill is expected to be amended to include federal agencies such as Centers for Disease Control, who use this data to

study disease epidemiology, and the Agency for Healthcare Research and Quality, for outcome studies and national healthcare quality benchmarking.

Healthcare Information Division Update: Mike Kassis, Deputy Director

- MIRCal/ALIRTS

Mr. Kassis introduced John Kriege, who has been devoting his attention to improving the health information management system as well as helping to implement ALIRTS (automation of the annual utilization report). ALIRTS replaces the two older systems of data collection. The annual utilization reports include reports from hospitals, long-term care facilities, clinics and home health agencies and hospices. Included for the first time are some licensing data. Users of the information (www.alirts.oshpd.ca.gov) need an internet browser. This will be incorporated into OSHPD's overall website, which is being developed now.

Mr. Kriege then demonstrated how information can be obtained in several ways by using facility name, license number, license name, etc. All of the information is provided by the facilities through ALIRTS. The annual utilization report is the only place to obtain financial information for surgical clinics, primary care clinics, and home health agencies. ALIRTS contains information for years 2002 and 2003 currently. Facilities are able to submit a report online and then revise it. The system contains built-in edits. Some of this information is obtain through the Department of Health Services' Licensing and Certification Section.

The ALIRTS has been out since last August. Staff is working on placing facilities in the appropriate Assembly, Congressional and Senate districts, as well as medical service study areas.

This information is useful for an average consumer of healthcare. Staff took the time in developing the system to try to determine what the data are that people want and to be able to access it easily. The system has been developed in modules, to enable modifications to add new kinds of data to be collected.

Introductions were made of key staff involved in the process of creating this system.

Mr. Kassis described XML, extensible markup language, which can pass information about data in a nationally accepted standard way.

One member said there is an effort underway to establish indicators on hospitals, and would be helpful. Dr. Carlisle indicated it is technically possible to link other outcome indicators on facilities via ALIRTS.

Some of OSHPD data is not completely in the data warehouse. Patient discharge data is being loaded into the warehouse, as well as some facility information. The objective over time is to load all the data into the warehouse where it can be categorized, stored and readily located. This will enable one to check on a particular facility, determine if it is an outstanding Cal-Mortgage loan, status of construction

projects, student financing through the educational program, licensing, financial and patient care data.

- Enterprise Geographical Information System (GIS): Scott Christman, GIS Coordinator and Mike Kassis

  The GIS system is basically an integration of database technology and the graphic display of maps. An industry magazine wrote that a decade ago that about 80 percent of healthcare transactions had significant geographic relevancy, and today the figure is closer to 100 percent. The GIS system allows for disparate datasets to be put into a geographic framework and then layer them together to show the whole picture.

  The enterprise GIS initiative for OSHPD began in the spring of 2001. GIS in State Government was always on a single project basis. OSHPD looked at the entire organization to find ways that GIS could benefit the business operations in OSHPD. A feasibility study was then submitted for approval of this project. This was the first of its kind to be approved by the State.

  A few years ago, CHPDAC issued a report as a result of SB 1109 legislation, with much input from the industry, public and others that said the data reporting and collection process (MIRCal) should be automated, as well as automation of the annual utilization reports (ALIRTS), and there should be better dissemination of the collected data.

  SB 1973 was the result of the SB 1109 report to implement the recommendations. There has been a three-year phased approach for GIS. During the feasibility study report, some business opportunities were identified for GIS, the first of which was healthcare facility locations. OSHPD has data on facilities, construction project information, Cal-Mortgage loan insurance information, seismic safety, hospital and long-term care financial, hospital patient discharge data, utilization, etc. In addition, there is information on facilities that receive grants for scholarships. Location of a facility was focused on. OSHPD has a mandate that in the case of a seismic event, to respond and inspect facilities for seismic safety. This planning will begin in June. The data query browse of ALIRTS allows the ability to quickly obtain information that OSHPD offers.

  Healthcare communities, basically representing the medical service study area (MSSAs), are the basis for many federal and state grants for healthcare work force and to clinics and facilities. OSHPD's outcome studies have been looking at trends over time, doing assessments of particular health issues. The Federal Government recognized MSSAs for the basis of medically underserved and health professional shortage area designations. MSSAs are based on census track, which is then reconfigured based on the new geography and the new data.

  GIS districting tools were used to designate legislative or county supervisory districts, as well as profiles of population, poverty, race, and ethnicity. OSHPD staff then met with local healthcare providers, clinic directors, public health officers,

stakeholders, etc. The new lines for MSSAs were created in conjunction with the local community and improved their competitiveness in the overall funding scheme at the federal level. There are 541 MSSAs and are based on census tracks. The California Cancer Registry is using the MSSA study as a unit for research on cancer.

During the next fiscal year, additional applications will be built, based on various program requirements and input from other stakeholders.

Mr. Christman when proceeded to demonstrate the system, answering any questions that arose during the presentation.

Testing of the system will be conducted during the next few weeks, and then a final build from the vendor. An infrastructure will be set up at the data center. A plan has already been developed to conduct a limited focused application on hospital information for release by the end of summer. Work will need to be done at the data center on information security, how the system works between fire walls, etc. The system will be in-house, available on the intranet. Discussions have occurred to extend the system to others such as Department of Health Services or other interested parties by a lock down. Additional applications useful to stakeholders and staff will be built.

Work will be done on importing zip code information to the MSSA. MSSAs can be used to look at population between certain periods of time, about poverty and the different characteristics that might complement disease or procedures in a particular area. Medi-Cal can be brought in through agreement with Department of Health Services. There has already been GIS work done in the WIC program, which geocoded the WIC incidence and caseload into community areas by census track. Discussions are ongoing with DHS about geocoding all the birth and death records.

The issue of confidentiality of data was discussed. The application would deliver the information, run a quick computation as to the cell size and if it did not meet the criteria, the information would not be displayed or would roll it up to a higher aggregate level.

OSHPD wants to make information available, but does not want to provide raw data, thus the reason for the query system. Filters are used to prevent a person from making sophisticated access. The public dataset, which has already masked the confidential data, is available to most requestors. Security of confidential data given to researchers is always a risk. Users must justify the use of requested data by going through CPHS, agree to keep the data in a locked room with restricted use, and return the data to OSHPD after it is no longer needed. The risk is now at an acceptable or minimal level with EGIS.

Ms. Ellis wanted it on the record that OSHPD is cognizant of the fact patient health information will include just a zip code and that alone could be confidential. OSHPD is aware of this and has addressed the issue.

Richard Thomason, Consultant to the Legislature, who was in the audience, said the Legislature will be very eager to use this tool when it is properly available.

Ms. Ellis said she thought it is not wrong to charge for this service considering how valuable it will be, even though OSHPD is philosophically against that. Dr. Carlisle added that the issue of access comes into play. Access is limited, sometimes to the groups needing it the most.

Ms. Ellis said OSHPD has done a phenomenal job and that the Discharge Data Section has won an award this year. The California Health Information Association nominated the Section to win a special friendship award. CHIA is acknowledging the value that OSHPD and the Discharge Data Section give to health information and the integrity of health information. They will be recognized at the annual convention.

Suggestion was made to call attention to this, ALIRTS, etc., by way of a press release or another means.

- Charge master Proposed Regulations: Kenny Kwong, Manager, Accounting and Reporting Section

  This is a continued discussion which began at the joint meeting of the Commission/Committee.

  Mr. Thomason gave some brief background as to how the charge master legislation came about. This came out of hearings that the Assembly Health Committee had last year, looking at specifically the billing practices of the Tenet Healthcare Corporation. Tenet had been engaging in billing practices that had gained their payment system from Medicare and from private payers through the operation of stop loss provisions in their contracts. Billing had been inflated as a way of hitting the outlier payment provisions and stop loss provisions in their contracts with insurers in ways that were not intended, either by Medicare or private payers. It was learned at that hearing that payers and purchasers really had very little idea of what the charges were that hospitals were using and little ability to have advance notion of hospitals that were using this particular method of gaming the system.

  There was a recommendation that making charge masters more of a public document would give purchasers, payers and sophisticated consumers more information about what different levels of charges were at different hospitals, as a way of helping them become better purchasers of care for the people that they insure. As this information becomes available through OSHPD, CalPERS and other sophisticated consumer groups could get some comparative information about what hospitals are doing with their relative levels of charges to each other and the marketplace.

  A second piece of legislation is trying to come up with some price information that would be useful to individual patients and consumers. As healthcare costs escalate, more and more costs will be shifted down to patients because coinsurance rates will be going up. The list of 25 common charges was a result of this. The State of

Wisconsin has been putting hospital-specific information on their website which breaks down average charges for some common DRGs at different hospitals. Having this sort of information on the internet is kind of the gold standard to move toward in the future, which will be more useful to patients to have information tied to a DRG. This was very user friendly.

As the legislation moved through the process, there were concerns about the cost of the bill. There were permissive provisions in the bill for OSHPD to begin collecting some of the DRG level price data and put it on the website. Mr. Thomason asked that OSHPD think about ways to move beyond the charge master information toward DRGs and other kinds of price information that would be more useful to consumers. The charge master filing is a starting point.

Ms. Ellis said there has been something similar in statute for many years for long-term care. Upon admission, LTC patients are given conditions of admission consent, which includes a schedule of fees for routine daily care and a schedule of fees for several things. Patients may not read these, but it is a notification. It is easily updated and is probably more comprehensive than the 25 elements currently requested in the law. LTC is much based on a daily rate, but does not include certain things, which are specified in the contract. If the rate is changed, a facility has to give a 30-day notice.

OSHPD collects data elements on each discharge, total charges. Each discharge includes diagnoses, procedures, payer disposition, and several other things. The diagnoses and procedures and other demographics are put through a DRG grouper, whether it is paid for on a DRG basis or not. Every discharge in the State database has a DRG and a major diagnostic category (DC), and the total charges.

The 25 common elements will not be the same for the first year as the hospitals can each select the elements. OSHPD has the authority to require them be the same, but it is not mandatory. The Legislature made an evaluation that it would be better to get some information to give consumers as a starting point.

Arizona has a similar law. Their state health departments put on the website a comparison of charges for all the hospitals in the state. OSHPD might focus on something like this if comparative information based on the charge master is released.

In the 2004-2005 budget, funding is being requested to implement the requirements of the law. OSHPD has the approach as a middle man, collecting the charge masters and making them available. There was no intent to develop a website and no personnel were identified to do the work. The charge master does not lend itself to an ALIRTS type of collection, as each hospital will not be giving the same data, in the same way, by the same definitions.

At this time, the intent of OSHPD is just to get this implemented and collect the data for at least one year. In order to do this, regulations must be in place.

Mr. Kwong explained the content of the regulations. Another document that will be filed in the second year of reporting is a calculated estimate of the percentage change in gross revenue resulting from a change or a price increase in the charge master. Supporting documentation is also requested. In taking the middle man approach, OSHPD wanted to create requirements that would be easy for the facilities to submit to OSHPD and also easy to handle internally and to disseminate.

It was recommended that Excel and PDF files be used and eliminate Word.

Estimated gross revenue is the language used in the legislation. Does it really mean estimate of the percentage increase in the hospital's gross revenue due to increase in charges for patient services during the 12-month period. If the revenue can be directly attributed to the fact that now you are charging more for a particular procedure or service, that is reportable. Hospitals will probably report four numbers: last year's gross, this year's gross, the difference, and the percentage change. If the percentage is big, then go into the details.

On July 1, 2004, hospitals will have to comply with the requirement that they either make their charge master available on the internet, on their website, or in an electronic or hard copy version on location. Notices will need to be in the emergency room, the billing office and admission office notifying patients that the charge master is available for review. The exception is small and rural hospitals would not have to make the charge master available on location, but would still report to OSHPD. Also, on July 2004, the list of 25 commonly charged items must be available on request.

An issue is if there are ownership changes during the year. Who is responsible for the charge master? This was not put in the regulations and can be handled through modification.

The California Healthcare Association is thinking of designing their own form and may pick out some routine room rates, such as semi-private, ICU, nursery, some ambulatory centers such as ER clinics and some of the ancillaries or common lab tests such as x-rays, physical therapy, etc.

OSHPD has sent two notices to facilities giving background information on the charge master requirements and the fact that regulations will be issued specifying some of the basic ideas of electronic submission and certain file types. Staff is in the process of developing an informational website which will include statutes and regulations and a list of frequently asked questions.

As the charge masters are being submitted, there will probably be a list of those facilities which have submitted. Dissemination will include announcing the availability of the information and procedures for making requests.

The proposed regulations will be an agenda item for action at the next California Health Policy and Data Commission's meeting on June 15. The proposed

regulations will have a 45-day comment period. Final submission to OAL will probably be sometime in September for filing.
As there was not a quorum, no motion was made. There was agreement that since this is in statute; OSHPD is trying to make the most of it. It was felt that disseminating this information will provide no value, especially since some of the charges are being submitted with the discharge data and could be linked and made available by DRG, through the ALIRTS system

Committee members said that OSHPD has done some wonderful work in making the information systems available and the charge master detracts from the good work, taking time and energy away from more productive work. The alternative would be to go back to the Legislature.

- Patient Discharge Data Section Update: Candace Diamond, Manager

  This Committee and the Commission considered regulations for the collection of emergency department and ambulatory surgery care. Since then, staff has done further work on the proposed regulations.

  Fine tuning of definitions has been made for the categories of expected source of payment which are probably more workable. Wording has been developed to be mutually exclusive so that the categories will not overlap.

  Collection of discharge data for the last half of 2003 has been completed. The due date was March 31. By May 21, all 475 hospitals had submitted data. Six hospitals were fined $100 each for being one day late; one appealed. One hospital was four days late.

Next Meeting: The next meeting date for the HDPIC will be sometime in September.

Adjournment: The meeting adjourned at 2:04 p.m.